IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF SOUTH CAROLINA

AIKEN DIVISION

American General Life Insurance Company, Plaintiffs, vs. Frances Sherlock and Tommy Jude Carroll, Defendants.	Civil Action No. 7 03 3722 24 COMPLAINT FOR DECLARATORY JUDGMENT

American General Life Insurance Company ("AGLIC"), as successor in interest to The Old Line Insurance Company of America, maintaining a principal place of business located at 2727 Allen Parkway, Houston, Texas 77019, by way of complaint against Frances Sherlock and Tommy Jude Carroll, alleges and says:

I. JURISDICTION

1. AGLIC is a life insurance company licensed in the State of Texas, maintains a principal place of business in the State of Texas, and is a citizen of the State of Texas within the meaning and intent of 28 U.S.C. § 1332.

2. Frances Sherlock allegedly maintains a primary residence located at 110 Saint Anthony Street, North Augusta, South Carolina 29861 and is a citizen of the State of South Carolina within the meaning and intent of 28 U.S.C. § 1332.

3. Tommy Jude Carroll is believed to maintain a primary address located in South Carolina and is a citizen of the State of South Carolina within the meaning and intent of

28 U.S.C. § 1332. The only known address for Mr. Carroll is P.O. Box 7234, North Augusta, South Carolina 29841.

4. The amount in controversy between the parties exceeds the sum of $75,000, exclusive of interest and costs of suit.

5. This court maintains jurisdiction pursuant to the parties' diversity of citizenship pursuant to 28 U.S.C. § 1332.

6. Venue in this judicial district is appropriate pursuant to 28 U.S.C. § 1391.

II. FACTUAL BACKGROUND

7. AGLIC is and during all relevant times has been in the business of underwriting and issuing policies of life insurance and is authorized to transact the business of insurance in the State of South Carolina.

8. On August 18, 2001, Frances Sherlock as named insured and owner, applied in writing to AGLIC seeking the issuance of a policy of life insurance bearing the policy number MM0269369L and containing an initial face amount death benefit of $100,000. The application for the policy of life insurance is incorporated by reference as if fully set forth herein.

9. In completing the application for life insurance, Frances Sherlock provided material information in response to questions presented on the application pertaining to, among other things, her health, medical condition, and identity.

10. In completing the application seeking the issuance of the life insurance policy from AGLIC, Frances Sherlock knew that she was required to provide truthful, accurate, and honest answers to the questions presented on the application.

11. In completing the application seeking the issuance of the life insurance policy from AGLIC, Frances Sherlock knew that AGLIC would rely upon the answers recorded on the application in determining whether she was insurable and qualified for the policy for which she applied.

12. In completing the application seeking the issuance of the life insurance policy from AGLIC, Frances Sherlock knew that she may be subject to civil and/or criminal penalties in the event she knowingly made a false statement in order to obtain an insurance policy and/or insurance benefits.

13. In completing the application seeking the issuance of the life insurance policy from AGLIC, Frances Sherlock represented that she was born on March 6, 1933; that her social security number was 247-27-3816; that she resided at 110 St. Anthony Street, North Augusta, South Carolina 29861; and that she had resided at this address for 28 years.

14. In completing Part A of the application seeking the issuance of the life insurance policy from AGLIC, Frances Sherlock represented, acknowledged, and agreed that "all statements and answers in this application are true, full and complete."

15. In completing Part A of the application seeking the issuance of the life insurance policy from AGLIC, Frances Sherlock signed Part A of the application.

16. At or about the same time Frances Sherlock executed Part B of the application seeking the issuance of the policy bearing Policy No. MM0269369L.

17. In completing Part B of the application, Frances Sherlock provided material information in response to questions presented on the application pertaining to, among other things, her health, medical condition, and identity.

18. In completing Part B of the application seeking the issuance of the life insurance policy from AGLIC, Frances Sherlock knew that she was required to provide truthful, accurate, and honest answers to questions presented on the application.

19. In completing Part B of the application seeking the issuance of the life insurance policy from AGLIC, Frances Sherlock knew that AGLIC would rely upon the answers recorded on the application in determining whether she was insurable and qualified for the policy for which she applied.

20. In completing Part B of the application seeking the issuance of the life insurance policy from AGLIC, Frances Sherlock knew that she may be subject to civil and/or criminal penalties in the event she knowingly made a false statement in order to obtain an insurance policy and/or insurance benefits.

21. In completing Part B of the life insurance application seeking the issuance of the life insurance policy from AGLIC, Frances Sherlock represented that she did not have a personal physician and did not have any of the medical conditions elicited in the written application.

22. In completing Part B of the life insurance application seeking the issuance of the life insurance policy from AGLIC, Frances Sherlock represented that she was 5'4" and weighed 170 pounds. No change of weight in the previous twelve months was disclosed.

23. On September 5, 2001, Frances Sherlock allegedly submitted to a medical examination. The person appearing for the exam was 5'3" and weighed 235 pounds.

24. On or about October 8, 2001, Frances Sherlock requested that AGLIC issue an additional policy of life insurance in the amount of $100,000. That policy is identified as Policy No. MM0179168L.

25. On the basis of the statements and representations and the written applications, and in reliance upon Frances Sherlock's complete candor, honesty, and openness in disclosing information in response to questions presented on the applications, AGLIC approved the issuance of a policy of life insurance bearing Policy No. MM0269369L and a policy of life insurance bearing Policy No. MM0179168L.

26. Policy No. MM0269369L of life insurance was issued November 28, 2001, and provides for a specified death benefit of $100,000. Policy No. MM0179168L was also issued on November 28, 2001, and provides for a specified death benefit of $100,000.

27. The policies of life insurance were delivered to Frances Sherlock.

28. The policies of life insurance contained language stating that each policy had a contestability period of two years.

29. During the application process, Frances Sherlock completed a second Part B form on or about September 5, 2001. On that form, Frances Sherlock listed her height as 5'2" and her weight at 190 pounds and she again denied having any weight change in excess of ten pounds in the previous year. Ms. Sherlock did acknowledge taking some medication and being treated for high blood pressure

30. On the Part B portion of the application completed and signed by Frances Sherlock on or about September 5, 2001, Frances Sherlock also indicated that her Social Security number was 249-27-3816.

31. In 2002, one or both policies of life insurance lapsed due to nonpayment of premium. Frances Sherlock sought the reinstatement of each policy of life insurance and submitted a Reinstatement Application along with a new Statement of Health. In signing the Statement of Health, Frances Sherlock acknowledged and agreed that "to the best of my

knowledge and belief, all statements and answers in the application are true, full and complete and bind all parties in interest under the policies."

32. On the Statement of Health made part of the Reinstatement Application, Frances Sherlock denied receiving medical advice or treatment for, among other things, high blood pressure or any other physical condition. Frances Sherlock also denied having consulted a physician or other practitioner concerning her physical or mental health.

33. In or around August 2002, Frances Sherlock submitted a Change of Ownership form for Policy No. MM0179168L, designating Tommy Jude Carroll as the policy owner. Mr. Carroll represented that his Social Security number is 248-77-6612 and that his address is P.O. Box 7234, North Augusta, South Carolina 29841. Mr. Carroll was named the policy's beneficiary in or around November 2002.

FIRST COUNT: DECLARATORY JUDGMENT

34. As AGLIC conducted a review of the life insurance policies, which are within the contestability period, AGLIC discovered, for the first time, that the statements and representations contained in the written applications were materially false; that Frances Sherlock and Tommy Carroll knowingly and intentionally failed and omitted to disclose material facts; that Frances Sherlock and/or Tommy Carroll intentionally failed to accurately, honestly, and/or truthfully answer and disclose material information in response to the questions presented on the written applications; that the misstatements, misrepresentations and/or omissions were material to AGLIC's risk; that AGLIC relied on said misstatements, misrepresentations and/or omissions; and that said misstatements, misrepresentations and/or omissions were made with the intent to deceive and to defraud AGLIC.

35. Specifically, Frances Sherlock failed to disclose information pertaining to her true identity in that she used multiple social security numbers.

36. Specifically, and on information and belief, Frances Sherlock did not live at the address written on her application for the policies of life insurance at the time the application was completed and signed, nor had she resided at the address for 28 years, as represented.

37. Specifically, and on information and belief, Frances Sherlock provided false and incorrect information regarding her health in completing the application by failing to disclose material and relevant information relating to her health, including, but not limited to, being treated for her weight and allegedly losing ten pounds in the year preceding the completion of her application and/or the issuance of the policies.

38. Specifically, and on information and belief, Frances Sherlock provided false and incomplete information in completing the Statement of Health associated with the reinstatement of her life insurance policies by falsely stating that she was not told or had never received medical advice or treatment for, among other things, high blood pressure or other physical disease or condition. Frances Sherlock also falsely denied having consulted a physician or other practitioner concerning her physical or mental health.

39. Specifically, Tommy J. Carroll failed to disclose information pertaining to his true identity in that he provided an incorrect Social Security number and uses multiple Social Security numbers.

40. The misstatements, misrepresentations, errors, and omissions described above in paragraphs 1 through 39, individually or collectively, were made for the purpose of obtaining the policies of life insurance for which Frances Sherlock applied and were relied upon by AGLIC in agreeing to issue Policy No. MM0269369L and Policy No. MM0179168L. But for

the misstatements, misrepresentations, errors, and omissions described above, either individually or collectively, AGLIC would not have issued the policies as written, if at all.

41. AGLIC has no adequate remedy at law and therefore seeks that the policies of life insurance bearing Policy No. MM0269369 and Policy No. MM0179168L be declared null and void and rescinded, *ab initio*, and that the Court grant AGLIC leave to deposit with the Clerk of the Court all premiums heretofore paid for coverage under the policies of life insurance and any interest owed pursuant to applicable law.

WHEREFORE, AGLIC demands judgment against Frances Sherlock for relief more particularly described as follows:

1. An order declaring and adjudging the policies of life insurance bearing Policy No. MM0269369L and Policy No. MM0179168L to be null and void and rescinded, *ab initio*;

2. An order permitting AGLIC to deposit with the Clerk of the Court all premiums heretofore paid for coverage under the policies of life insurance and any interest owed pursuant to applicable law; and

3. An order awarding prejudgment interest, post judgment interest, cost of suit, reasonable attorneys' fees and such other relief as this Court deems equitable and just to AGLIC.

SIGNATURE PAGE ATTACHED

NELSON MULLINS RILEY & SCARBOROUGH, L.L.P.

By: _____

C. Mitchell Brown
Federal Bar No. 5283
Keenan Building, Third Floor
1330 Lady Street
Post Office Box 11070 (29211)
Columbia, SC 29201
(803) 799-2000

Attorneys for American General Life Insurance Company

Columbia, South Carolina

11/24, 2003

Of Counsel:

David T. McDowell
State Bar No. 00791222
Kirsten Barron Cohoon
State Bar No. 24034382
BRACEWELL & PATTERSON, L.L.P.
South Tower Pennzoil Place
711 Louisiana, Suite 2900
Houston, TX 77002
(713) 223-2900
fax: (713) 221-1212

EXHIBIT
(APPLICATION DOCUMENTS)

Application for life insurance to

THE OLD LINE LIFE Insurance Company of America

(referred to in this application as we/us/our)

9/24/019:30A

PART A 503648000156

COMPLETE FOR ALL POLICIES (Please Print) — Questions 1a through g apply to Proposed Insured

1. a. NAME (first, middle, last) Francis C. Sherlock ☐ Male ☑ Female

b. ☐ Single ☐ Married ☐ Divorced ☑ Widowed ☐ Separated

c. DATE OF BIRTH (month day year) 03-4-32 d. AGE 68 e. BIRTHPLACE (state) SC (county) Aiken

f. SOCIAL SECURITY OR TAX NO. 247-37-3816

g. HOME TELEPHONE NO. 803-819-3665

2. SEND ALL MAIL TO OWNER AT ADDRESS IN ☐ 3a ☒ 3b ☐ 9

3. a. RESIDENCE ADDRESS OF PROPOSED INSURED

No. & Street 110 St Anthony St

City N. Augusta State SC Zip 29841

How long at this address? 24 yrs. Previous Addresses (5 Yrs.)

QUESTIONS 3b & c APPLY TO PROPOSED INSURED IF AGE 15 OR OVER. TO OWNER OR PAYOR IF PROPOSED INSURED UNDER AGE 15.

b. BUSINESS ADDRESS with present employer ____ yrs.

Employer Home maker

No. & Street PO Box 6778

City N. Augusta State SC Zip 29841

Nature of Business House keeping

c. OCCUPATION (All, if more than one) ____

Duties (Describe) ____

4. HAS ANY PERSON PROPOSED FOR INSURANCE:	Yes	No
a. smoked cigarettes during the past 12 months?	☐	☒
b. smoked pipes or cigars during the past 12 months?	☐	☒
c. used any other tobacco products during the past 12 months?	☐	☒
5. HAS ANY PERSON PROPOSED FOR INSURANCE:		
a. engaged, or intend to engage, in hang gliding, racing, scuba diving, sky diving?	☐	☒
b. had driver's license restricted, revoked or suspended? If yes, give driver's ID#.	☐	☒
c. other life insurance applications pending?	☐	☒
d. ever had life or health insurance declined, modified or rated? Due to weight	☒	☐
e. any intention of traveling or residing outside the U.S.?	☐	☒
f. any intention of replacing or changing any life insurance or annuity policy in force in this or any other company?	☐	☒

If any of 5a through 5f are answered Yes, give names & full details in REMARKS.

g. taken within five years or intend to take flights other than as fare-paying passenger on scheduled airlines? *If Yes, complete Aviation Questionnaire.*	☐	☒

AMENDMENTS AND CORRECTIONS (for Home Office use only)

6. a. PLAN ☐ Non Par ☐ Par — b. AMOUNT 100,000

c. PREMIUMS PAYABLE ☐ Annual ☐ Semi-annual ☐ Quarterly ☒ Pre-Auth. Chk. ☐ GAP ☐ List Bill ☐ ____

d. For Universal Life only:

☒ Option 1 ☐ Option 2 MM0269369

Planned Premium $ ____

Additional Initial Premium $ ____

e. AUTOMATIC PREMIUM LOAN, if available ☒ Yes ☐ No

f. ADDITIONAL COVERAGES (Check if desired)

☐ WP or WMD ☐ ____

☐ ADB $ ____ ☐ GIO ____ Units

☐ Spouse Rider ____ Units ☐ Child Rider ____ Units

☐ Term Rider Plan ____ $ ____ (Amt. or M.I.)

☐ Term Rider on Other Insured — use separate application

g. IF PARTICIPATING, USE OF DIVIDENDS

	Purchase 1 Yr. Term, balance to:
☐ (1) Cash	☐ (5) Deposit at Interest
☐ (2) Reduce Premium	☐ (6) Reduce Premiums
☐ (3) Paid Up Additions	☐ (7) Purchase Paid Up Additions
☐ (4) Deposit at Interest	☐ (8) Use All to Purchase 1 Yr. Term

7. LIFE INSURANCE IN FORCE ON PROPOSED INSURED

Name of Company	Issue Year	Amount	ADB	Personal/Business
UPL	94	20,000		

8. BENEFICIARY for benefits payable upon death of the proposed insured

	Full Name	Age	Relationship
Primary:	Catherine M. Carroll		Daughter
Contingent:			

Except as otherwise directed: (a) The proceeds are to be divided equally among all persons who are named as Primary Beneficiary and who survive the insured, but if none survive, equally among all persons who are named as Contingent Beneficiary and who survive the insured. (b) The right to change the beneficiary is reserved.

9. NAME OF OWNER if other than proposed insured Relationship

Address

Social Security or Tax No.

10. SPECIAL POLICY DATE, IF DESIRED

11. AMOUNT PAID WITH THIS APPLICATION: $ 0.00

12. REMARKS Request Additional Policy for 100,000

Also SC Approved for 105 From Shawmut but have not heard from Agent

This application consists of Part A and one or more Parts B. This application is not a contract of insurance. A contract of insurance shall take effect only if a policy is issued on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds and (b) while there is no change in the insurability and health of all such persons from that stated in this application. However, if cash is paid when this application is signed, the terms of the Conditional Receipt shall apply. It is represented that all statements and answers in this application are true, full and complete, and bind all parties in interest under any policy applied for. Only an authorized officer of our Company can make, void, waive or change any of the conditions or provisions of any application, policy or receipt or accept risks or pass on insurability. Acceptance of any policy issued on this application shall mean acceptance of any change, correction, addition or amendment noted by us in the "Amendments and Corrections" Section. However, any such change shall require the written consent of the person or persons who sign this application. The Proposed Insured shall be the policy owner unless another owner is named above.

DECLARATION

I have carefully read the receipt, I understand and agree to its terms including the conditions under which a limited amount of insurance may take effect before policy delivery. I have received the MIB, Inc. and Fair Credit Reporting Act Notices.

Signed at City N. Augusta State SC

Date 4-16-01

Witness ____
(LICENSED RESIDENT AGENT WHERE REQUIRED BY STATUTE OR REGULATION)

Signature of Proposed Insured X Francis C Sherlock

Signature of Spouse (Spouse Rider Only) ____

Signature of Owner (if 9 answered) ____
SIGNATURE & TITLE OF OFFICER SIGNING FOR CORP OR TRUSTEE

Form 4485-P (Rev. 88)

FF-04001000-1047-1196 (Page 1 of 5)
Supply Ordering Number-04201000-1264-1196 (Page 1 of 5)

9/24/019:30A

THE OLD LINE LIFE Insurance Company of America

(referred to in this application as we/us/our)

1. PROPOSED INSURED (Person Named on 1a Part A) — A. Height 5 ft. 4 in. — B. Weight 170 lbs. — C. Change in weight in past 12 months, *(Give reason)* lbs. Loss _____ Gain _____

2. FULL NAME(S) OF ADDITIONAL INDIVIDUAL(S) PROPOSED FOR INSURANCE (PLEASE PRINT) first middle last	DATE OF BIRTH month day year	Age	Sex	Place of Birth	Height ft. in.	Weight lbs.	Total Insurance in Force
a. SPOUSE OR PAYOR (If proposed for insurance)							
b. CHILDREN (If proposed for insurance and residing with Proposed Insured)							

3. Name and address of your personal physician (if none, so state)

QUESTIONS 4-8 PERTAIN TO ALL PERSONS NAMED ABOVE AND ARE TO BE ANSWERED TO THE BEST OF THE APPLICANT'S KNOWLEDGE AND BELIEF

GIVE FULL DETAILS IF ANSWER TO QUESTION 4 IS NO OR 5, 6, 7, 8 IS YES

	Yes	No
4. Are all persons proposed for insurance in good health?	☒	☐
5. Has any person proposed for insurance any physical defect?	☐	☒
6. HAS ANY PERSON PROPOSED FOR INSURANCE:		
a. received treatment or joined an organization for alcoholism or drug dependency or abuse; been advised to discontinue the use of alcohol or drugs?	☐	☒
b. used cocaine, barbiturates, amphetamines or any other drug which might cause a dependency, other than as prescribed by a licensed physician?	☐	☒
c. ever had or been told they had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☒
d. ever applied for or received disability benefits from any source?	☐	☒
7. HAS ANY PERSON PROPOSED FOR INSURANCE EVER HAD:		
a. convulsions, epilepsy, paralysis, neuritis, sciatica, nervous breakdown, headache, dizziness, fainting spells, speech defect, nervous or mental disorder?	☐	☒
b. high blood pressure, chest pain, palpitation, heart attack, stroke, heart murmur, hemorrhage, rheumatic fever, disorder of heart or blood vessels?	☐	☒
c. persistent hoarseness or cough, shortness of breath, asthma, emphysema, tuberculosis, bronchitis, disorder of respiratory system?	☐	☒
d. recurrent indigestion, ulcer, colitis, diverticulitis, hernia, intestinal bleeding, appendicitis, disorder of stomach, liver, digestive or abdominal organs?	☐	☒
e. sugar, albumin, blood or pus in urine, kidney stone, diabetes, or disorder of kidneys, bladder, prostate, or genito-urinary organs?	☐	☒
f. arthritis, gout, disorder of muscles, bones, joints or spine?	☐	☒
g. impairment of vision or hearing or disorder of eyes, ears, nose or throat?	☐	☒
h. tumor, cyst, cancer, hemorrhoids, venereal disease, anemia, disorder of blood, skin, thyroid or other glands?	☐	☒
i. treatment or observation in any hospital or institution? (past 5 years)	☐	☒
j. X-ray or electrocardiograms? (past 5 years)	☐	☒
k. treatment or consultations with any physicians or practitioners, other than as stated above? (past 5 years)	☐	☒
8. Is any person proposed for insurance now pregnant? (If so, how many months?)	☐	☒

Name of Person	Details, Dates, Doctors' Names & Addresses

COMPLETE IF PROPOSED INSURED UNDER AGE 15

9. List life insurance in force on family *(if none, so state)*

	Age	Amount		Age	Amount
Father			Mother		
Brothers			Sisters		

Owner (if other than parent) $ _____

COMPLETE IF PROPOSED INSURED AGE 15 OR OVER & NOT SELF-SUPPORTING

10. Parent's/Spouse's full name _____
11. Parent's/Spouse's occupation _____
12. How much insurance does Parent/Spouse carry? _____
13. Does Proposed Insured have an independent source of income? (state source) _____

Signature of Proposed Insured _____

Witness _____ *(LICENSED RESIDENT AGENT WHERE REQUIRED BY STATUTE OR REGULATION)*

Signature of Spouse (if required) _____

Signature of Owner (if required) _____

Form 4485-P (Rev. 88)

Is policy intended to replace insurance or annuity in any company? ☐ Yes ☒ No If Yes, give full details and attach any other papers required by state law.

Are you related to any person proposed for insurance? ☐ Yes ☒ No If Yes, give details _____

PRODUCER'S REPORT

Estimate of Proposed Insured's Income: Salary $ 21,000 Other Income $ 500 Net Worth $ 100,000+

Mercier Ins	Oakland	C. Mercier	0K102
AGENCY OR BRANCH OFFICE	CODE NO.	PRODUCER'S NAME FOR RECORD PURPOSES (IF MORE THAN ONE INDICATE % SPLIT)	CODE NO.

I hereby certify that I personally solicited and completed this application; that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein.

_____ SIGNATURE OF PRODUCER

AUTHORIZATION A photo copy of this authorization shall be as valid as the original.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. or other organization, institution or person that has any records or knowledge of me or my health, to give The Old Line Life Insurance Company of America or its reinsurers any such information. This includes that information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s) and referred to elsewhere in this application for insurance. To facilitate the rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency employed by The Old Line Life Insurance Company of America to collect and transmit such information. This authorization will be valid for 30 months from the data of this application.

x Francis C. Shilock

SIGNATURE OF PROPOSED INSURED (OWNER IF PROPOSED INSURED UNDER AGE)

8/18/2001

DATE

SIGNATURE OF SPOUSE (IF PROPOSED FOR INSURANCE)

Part B

Single Insured Life Insurance Application

AMERICAN GENERAL FINANCIAL GROUP

NM0269369L ☐ American General Life Insurance Company, Houston, TX
☒ The Old Line Life Insurance Company of America, Milwaukee, WI
NM0179169L ☐ All American Life Insurance Company, Springfield, IL
☐ The Franklin Life Insurance Company, Springfield, IL
☐ The American Franklin Life Insurance Company, Springfield, IL

Members of American General Financial Group. American General Financial Group is a marketing name for American General Corporation and its subsidiaries.

In this application, the "Company" refers to the insurance company whose name is checked above.

The insurance company checked above is solely responsible for the obligation and payment of benefits under any policy that it may issue. No other company shown is responsible for such obligations or payments.

Personal and Employer Information

Proposed Insured

Name Francis C. Shudak
Social Security # 249-27-3916 Date of birth 3-6-33
Employer Unemployed
Employer address N/A
Zip N/A Phone # N/A Length of employment N/A
Net worth $ 100,000 Household income $ Same

Background Information

Provide any additional details to "yes" answers for questions 1–6 in the "Remarks" section on page 4.

Francis C. Shudak
Proposed Insured

1. Do you intend to travel or reside outside of the United States or Canada within the next two years?
☐ yes ☒ no
Country, purpose, and date

2. In the past five years, have you participated in, or do you intend to participate in: any flights as a trainee, pilot or crew member; scuba diving; skydiving or parachuting; ultralight aviation; auto racing; cave exploration; hang gliding; boat racing; mountaineering; or other hazardous activities?
☐ yes ☒ no *If yes, complete the Aviation and/or Avocation Questionnaire.*

3. Has proposed insured:
a) during the past 90 days submitted an application for life insurance to any other company or begun the process of filling out an application?
☐ yes ☒ no *If yes, explain.*
Shearson app. pending
b) ever had a life or disability insurance application modified, rated, declined, postponed, withdrawn, cancelled, or refused for renewal?
☐ yes ☒ no *If yes, explain.*

Background Information continued MM02693694 : MM01791684

4. Have you ever filed for bankruptcy?
☐ yes ☒ no
Type of bankruptcy
Date Date of discharge

5. In the past five years, have you been charged with or convicted of driving under the influence of alcohol or drugs, or had two or more driving violations?
☐ yes ☒ no *If yes, explain.*
State License #

6. Have you ever been convicted of or pled guilty or "no contest" to a felony or do you have any such charge pending against you?
☐ yes ☒ no *If yes, explain.*
State Date

Medical History

Provide any additional details for answers to questions 7-9 in the "Remarks" section on page 4.

Proposed Insured

7. Name and address of your personal physician(s). *Write "none" if you don't have one.*
Dr Courtney Gentry
(609 15th St, Augusta, Ga. 3091)
Date, reason, findings of last visit.
7/2004 — 3 mos. check up visit

8. Height and weight.
5' 2" lb. 150 lbs.
Have you had any weight change in excess of 10 lbs. in the past year?
☐ yes ☒ no *If yes, explain.*

9. What is your family history?

Proposed Insured	Age if living	Age at death	Current condition or cause of death
Father		76	COPD, Dz pneu HX
Mother		65	Breast cancer

Medical History continued MM0269369L ! MM0179168L

For questions 10-16, provide additional information as requested in the "Remarks" section on page 4.

Proposed Insured: Thomas C. Shadrick

10. Have you ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:
    a) any heart disease, heart attack, chest pain, irregular heart beat, high cholesterol, high blood pressure, or any other disorder of the heart or blood vessels? ☑ yes ☐ no
    b) any blood clot, aneurysm, stroke, or other disease, disorder, or blockage of the arteries or veins? ☐ yes ☑ no
    c) any cancer, cysts, tumors, masses, or other such abnormalities? ☐ yes ☑ no
    d) diabetes, disorder of the thyroid or other glands, immune system disorder, or blood or lymphatic system disorder? ☐ yes ☑ no
    e) any disorder of the stomach or liver, colitis, hepatitis, or any disorder of the digestive system or other such organs? ☐ yes ☑ no
    f) any disorder of the kidneys, prostate, urinary system, or reproductive organs? ☐ yes ☑ no
    g) any asthma, bronchitis, emphysema, sleep apnea, or other breathing or lung disorders? ☐ yes ☑ no
    h) any brain or spinal cord disorders, seizures, or other nervous system abnormalities including mental and nervous disorders? ☐ yes ☑ no
    i) arthritis, muscle disorders, or other bone or joint disorders? ☐ yes ☑ no
11. Are you currently taking any medication, treatment, or therapy, or are you under medical observation? ☑ yes ☐ no
12. Have you in the past three years had:
    a) fainting spells, nervous disorders, headaches, convulsions, or paralysis? ☐ yes ☑ no
    b) any pain or discomfort in the chest or shortness of breath? ☐ yes ☑ no
    c) disorders of the stomach, intestines, or rectum, or blood in the urine? ☐ yes ☑ no
13. Have you ever:
    a) sought or received advice, counseling, or treatment by a medical professional for the use of alcohol or drugs including prescription drugs? ☐ yes ☑ no
    b) used cocaine, marijuana, heroin, controlled substances, or any other drug except as legally prescribed by a physician? ☐ yes ☑ no

    (If "yes" answered to a or b, complete Drug/Alcohol Questionnaire.)
14. Have you ever been diagnosed or treated by any member of the medical profession for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ yes ☑ no
15. In the past 10 years, have you:
    a) been hospitalized, consulted a health care provider, or had any illness, injury, or surgery? ☐ yes ☑ no
    b) had any laboratory tests, treatments, or diagnostic procedures, including x-rays, scans, or EKGs? ☑ yes ☐ no
    c) been advised to have any diagnostic test, hospitalization, or treatment that was not completed? ☐ yes ☑ no
    d) received or claimed disability or hospital indemnity benefits or a pension for any injury, sickness, disability, or impaired condition? ☐ yes ☑ no

503827 003003

Medical History continued MM02693694 : MM0179169 [signature]

	Proposed Insured
16. Do you have any symptoms or knowledge of any other condition that is not disclosed above?	☐ yes ☒ no

Remark

Identify question number and provide details to any questions answered "yes" in the "Background Information" and "Medical History" sections. Include such details as: date of first diagnosis; name and address of doctor; tests performed; test results; medication(s) or recommended treatment. If necessary, attach additional pages to record responses.

10-A ↑BP onset 1997
Sun de #7
Tx: Nifedipine 30 mg - qd
continued

11- See 10 A

15 B. EKG done 1998 as part of physical Wnl
Sun de #7

Statements by the proposed insured

I have read the above statements or they have been read to me. The above statements are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and, if applicable, Part C and related forms; and (2) shall be the basis for any policy issued on this application. Except as may be provided in a Limited Temporary Life Insurance Agreement (LTLIA) for which all eligibility requirements are met, I understand and agree that no insurance will be in effect pursuant to this application, or under any policy issued by the Company, unless or until: the policy has been delivered and accepted; the full first modal premium for the issued policy has been paid; and there has been no change in the health of the proposed insured that would change the answers to any questions in the application.

I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts, or waive any of the Company's rights or requirements.

Insurance fraud

Any person who, with intent to defraud or facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signatures

X Owner Frances C Sherlock Date 9-5-01

Signed at (city, state) N Augusta, S.C.

X Witness Barbara Brownlee Date 9-5-01

X Proposed insured Frances C Sherlock Date 9-5-01

(If under age 15, signature of parent or guardian)

I certify that I have truthfully and accurately recorded on the Part B application the information supplied by the proposed insured.

Agent name *(please print)* Tony Dearduff

Agent # State license #

X Agent Date

MM0269869L & MM0179168L

BARBARA PAGE 06

[redacted] CLINICAL REFERENCE LABORATORY

8433 Quivira Road • Lenexa, Kansas 66215

NM0269786L

NM017791682

CRL INTERNAL USE ONLY | LAB CODE | G

0028050317

Field	Entry
INSURANCE COMPANY NAME	OLD LINE LIFE
CITY	MILWAUKEE
STATE	WI
REGIONAL OFFICE	
AGENT NUMBER OR CODE	
AGENT NAME	TONY MERCER
TYPE OF INSURANCE	INDIVIDUAL ☒ GROUP ☐ LIFE ☒ HEALTH ☐ OTHER ☐ DISABILITY ☐ MAJOR MED. ☐ LONG-TERM CARE ☐ CRITICAL ILLNESS ☐ BROKERAGE ☐
AGENCY NAME	
POLICY NUMBER	
LAST NAME	SHERLOCK
POLICY AMOUNT	120,000
FIRST NAME	FRANCES C
DATE OF BIRTH	[illegible]
SOCIAL SECURITY NUMBER	247-27-3816
GENDER	M
DRIVER'S LICENSE NUMBER	001857198
STREET ADDRESS	PO BOX 6778
STATE	SC
PICTURE VERIFIED	☒ YES ☐ NO
ZIP CODE	29841
E-MAIL ADDRESS	
CITY	N AUGUSTA
STATE	SC
DATE AND TIME OF LAST FOOD AND DRINK	[illegible]
DATE AND TIME SPECIMEN WAS OBTAINED	[illegible]
SPECIMEN TEMPERATURE	96
DATE AND TIME BLOOD CENTRIFUGED	[illegible]

1. DO YOU SMOKE CIGARETTES? ☐ YES ☒ NO
a. IF NO, HOW LONG SINCE YOU LAST SMOKED CIGARETTES? ☐ MO. ☒ NEVER
b. DO YOU USE ANY TOBACCO PRODUCTS? ☐ YES ☒ NO
c. IF NO, HOW LONG SINCE YOU LAST USED TOBACCO PRODUCTS? ☐ MO. ☒ NEVER
d. DO YOU USE A NICOTINE SUBSTITUTE (i.e. gum or patch)? ☐ YES ☒ NO

2. Any history of Diabetes? ☐ YES ☒ NO High blood pressure? ☒ YES ☐ NO Protein/Albumin in urine? ☐ YES ☒ NO
3. In the past 5 years, have you had a moving violation or your driver's license restricted, suspended or revoked? ☐ YES ☒ NO
4. Are you currently taking any prescription medications? ☒ YES ☐ NO If yes, please list: Medicine
5. Currently Pregnant? ☐ YES ☒ NO

"DO NOT COMPLETE THIS SECTION UNLESS INSTRUCTED BY THE INSURANCE COMPANY"

Field	Entry
HEIGHT	5 FT 3 IN
WEIGHT	235 LBS
BLOOD PRESSURE SYSTOLIC 1ST	126
DIASTOLIC 1ST	62
2ND	—
3RD	—
PULSE RATE AT REST	72
IRREGULARITY	0
MALE APPLICANT ONLY: CHEST (full inspiration) / CHEST (forced expiration) / ABDOMEN at umbilicus	NA / NA / NA

EXAMINER COMPANY: ☐ APPS ☐ EMSI ☐ EXAMONE/HOOPER ☐ HEALTHQUARTERS ☒ PORTAMEDIC OTHER ______

Field	Entry
PHONE	(706) 738-2282
EXAMINER NAME	B BRAY [illegible]
CITY	AUGUSTA
STATE	GA
ZIP	30907

SPECIAL TESTS: ☐ FULL DRUG ☐ MICROALBUMIN ☐ A1C ☐ CBC ☐ CDT ☐ HIV ONLY ☐ PSA ☐ OTHER ______

COMMENTS ______

...owing my samples to be collected, I have read and understand the notice and consent for testing ...include AIDS (HIV) antibody testing, which appears on the reverse side of this form. I voluntarily ...the withdrawal of blood from me by needle or lancet and the testing of any blood/urine/or oral ...fluid, by CRL. Furthermore, if my urine is to be tested for HIV antibodies, I have read and ...the Calypte subject information brochure entitled "Urine Testing for Antibodies to HIV-1" that ...to me by the collector. I authorize the release of the test results and other information about me ...but not limited to medical information) for disclosure as described on the reverse side of this ...her acknowledge receipt of a copy of this form signed by me. ...MPT BY THE PROPOSED INSURED TO MODIFY OR AMEND THIS FORM WILL CHANGE ...S OR IN ANY WAY BE BINDING UPON THE INSURANCE COMPANY OR ANY OF ITS ...OR CONTRACTORS. ...posed Insured, verify that the enclosed contents of these container(s) are indeed my ...for oral fluid specimens, I verify that the proper bar code label is affixed to each specimen ...and that my urine was collected into vials that were sealed with tamper-evident tape that I have ...signed.

Frances C Sherlock 9-5-01

Proposed Insured's Signature / Date

COLLECTOR VERIFICATION

[illegible] PRINT NAME

I verify that the enclosed specimens were collected according to the specimen criteria on the instruction sheet provided by Clinical Reference Laboratory. I further verify that these specimens are in fact the specimens taken from the proposed insured named on this ID form. I have placed the barcode label(s) on the appropriate specimen vials and the tamper-evident tape on the urine vials for the proposed insured named on this ID form.

[signature]

(Signature of Examiner/Collector and Date)

LAB USE ONLY

These specimens were delivered ... belonging to the proposed insured named above unless indicated below. There is no apparent evidence of tampering.

LABORATORY RECEIVING Date

ORIGINAL TO LAB

0028050317

HM0269369L

707 North Eleventh Street • PO Box 401
Milwaukee WI 53201-0401

THE OLD LINE LIFE Insurance Company of America

HM0179168L

NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND CONSENT FOR TESTING

5

Examiner BARBARA GROVES, R.N.

PORTAMEDIC
[redacted] MARKS CHURCH RD., UNIT B
AUGUSTA, GA 30909
22-1680303

The Tests

To evaluate your eligibility for insurance or insurance benefits, it is requested that you provide a sample of your blood for testing and analysis. One of the tests to be performed on this sample may be a test to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related blood test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Disclosure of Test Results

All test results will be treated confidentially. The results of the test will be reported to the insurer named above. The results also may be reported to the insurer's employees who have the responsibility to make underwriting decisions on behalf of the insurer, the insurer's affiliates, reinsurers, or legal counsel who need such information to effectively represent the insurer in connection with insurance you have or have applied for. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific blood abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you. You are also requested to list your private physician or health care provider for reporting positive or indeterminate test results.

Name and Address of physician or health care provider for reporting a positive or indeterminate test result: _____

_____

Meaning of Test Results

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred with the previous 3-6 months.

If your antibody test is positive, it does not mean that you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needs, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible. Positive HIV antibody test results will adversely affect your insurance application.

A negative test result means no antibodies to the HIV virus were found. Because of various incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Nor does absence of HIV antibodies mean that you are immune to the virus.

Additional information about AIDS and the HIV infection can be obtained by contacting an AIDS Service Group in your area.

Consent

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to the withdrawal of blood from me, the testing of my blood for HIV antibodies, and the disclosure of the test results as described above.

Francis C. Sherlock
Name of Proposed Insured (Please Print)

3-6-33
Birth Date

Francis C. Sherlock
Signature of Proposed Insured

9-5-01
Date

SC
State of Residence

W-BLD DISTRIBUTION COPY—AAA COPY—INSURED COPY—PROPOSED INSURED COPY—[illegible]

NAME: SHERLOCK, FRANCES C.
DOB/AGE:03/06/1933 (68 YRS)
SSN: 249-27-3816
GENDER: FEMALE
CITY: N AUGUSTA
STATE/ZIP: SC/29841
DL#/ST: 001857198/SC

OLD LINE LIFE INS CO
OLD LINE LIFE OF AMERICA
DR STEVEN E ZIMMERMAN MD
POLICY/REF#: N/S
POLICY AMT: $ 100,000
AGENCY: N/S
EXAMINER: 3ORTAMEDIC
INSURANCE TYPE: IND-LIFE

SAMPLE ID: 86896955
SLIP ID: 0028050317
DRWN: 09/05/2001 12:00
RCVD: 09/06/2001 11:58
SENT: 09/06/2001 21:47
LAST FOOD: 14 HRS
URINE TEMP: IN RANGE

DOCUMENTS RECEIVED AND PROCESSED

	RESULT/STATUS		CUTOFF/EXPECTED VALUE
CHEMISTRIES			
GLUCOSE	93		70-125 mg/dL
FRUCTOSAMINE	1.8		1.2-2.6 mmol/L
BLOOD UREA NITROGEN (BUN)	13		6-25 mg/dL
CREATININE	0.8		0.6-1.5 mg/dL
URIC ACID	5.9		2.5-7.5 mg/dL
ALKALINE PHOSPHATASE	78		30-115 U/L
TOTAL BILIRUBIN	0.5		0.1-1.2 mg/dL
SGOT (AST)	19		0-41 U/L
SGPT (ALT)	20		0-45 U/L
GAMMA GLUTAMYLTRANSFERASE	18		2-65 U/L
TOTAL PROTEIN	7.8		6.0-8.5 g/dL
ALBUMIN	4.5		3.0-5.5 g/dL
GLOBULIN	3.3		1.0-4.5 g/dL
CARDIAC RISK			
CHOLESTEROL	259		120-260 mg/dL
HIGH DENSITY LIPOPROTEIN(HDL)	70		25-75 mg/dL
LOW DENSITY LIPOPROTEIN (LDL)	166		60-190 mg/dL
TRIGLYCERIDES	114		10-200 mg/dL
CHOLESTEROL/HDL RATIO	3.70		1.50-5.00
LDL/HDL RATIO	2.37		0.00-3.60
HIV SCREENING			
HIV-EIA		NON-REACTIVE	
URINALYSIS			
URN SPECIFIC GRAVITY	1.035		1.003-1.035
URN CREATININE	265.0		10.0-300.0 mg%
URN GLUCOSE	0.00		0.00 g/dL
URN TOTAL PROTEIN	16.0	HIGH	0.0-14.9 mg/dL
URN PROTEIN/CREATININE	0.06		0.00-0.20 g/gCREA
URN RED BLOOD COUNT	0		0 HPF
URN WHITE BLOOD COUNT	0		0-9 HPF
URN HYALINE CASTS	0		0 LPF
URN GRANULAR CASTS	0		0 LPF
DRUG SCREENING			
COCAINE METABOLITES		NEGATIVE	300 ng/mL
URN-NICOTINE		NEGATIVE	
EXAM INFORMATION			
HEIGHT	5' 3.0"		
WEIGHT	235		
BLOOD PRESSURE 1ST	124/62		
BLOOD PRESSURE 2ND	.....	N/S	
PULSE STANDARD-AT REST	72		

PULSE IRREGULAR-AFTER EXERCIS ..... N/S

CRL, 8433 Quivira, Lenexa, KS 66215 (913) 492-3652

< END OF REPORT >